

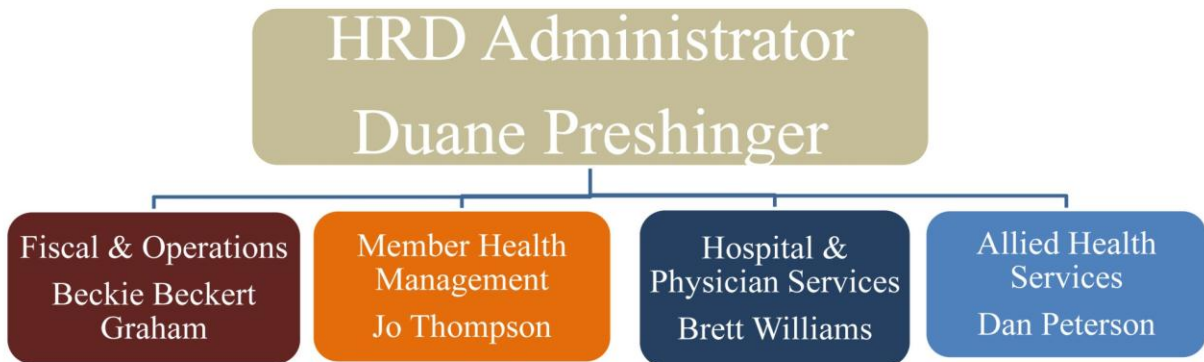


Presentation to the 2015 Health and Human Services
Joint Appropriation Subcommittee

HEALTH RESOURCES DIVISION

Department of Public Health and Human Services
Legislative Fiscal Division Budget Analysis, Volume B, Page 80-99

Organizational Chart



CONTACT INFORMATION

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OVERVIEW

The Health Resources Division (HRD) administers Medicaid preventative, primary care and acute care services, the Healthy Montana Kids (HMK) benefit, and the Big Sky Rx program. These programs work in coordination with other programs within DPHHS to provide healthcare benefits to low-income Montanans.

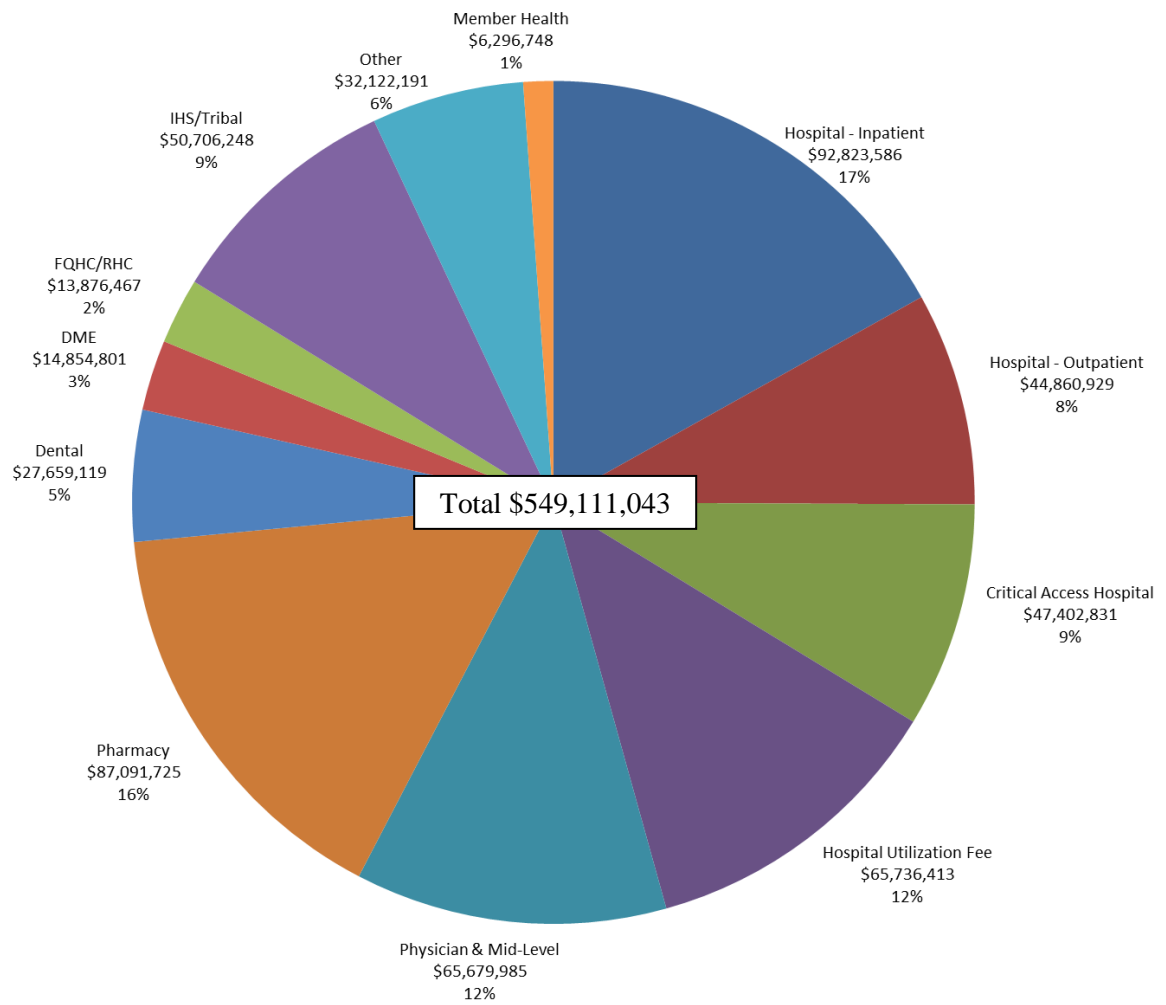
Medicaid is a state/federal partnership that reimburses for medical services provided to the aged, blind, disabled, and low-income families. HMK is Montana's health care program for children; it matches state funds with federal Medicaid and CHIP dollars to reimburse for comprehensive health care. The Big Sky Rx is a premium assistance program that assists seniors in maintaining pharmacy benefit coverage.

HRD manages over 60 separate medical services available statewide in addition to managing three waivers: Section 1115 Basic Medicaid Waiver, Section 1115 Plan First Family Planning Waiver, and a Section 1915(b) Passport to Health Managed Care Waiver.

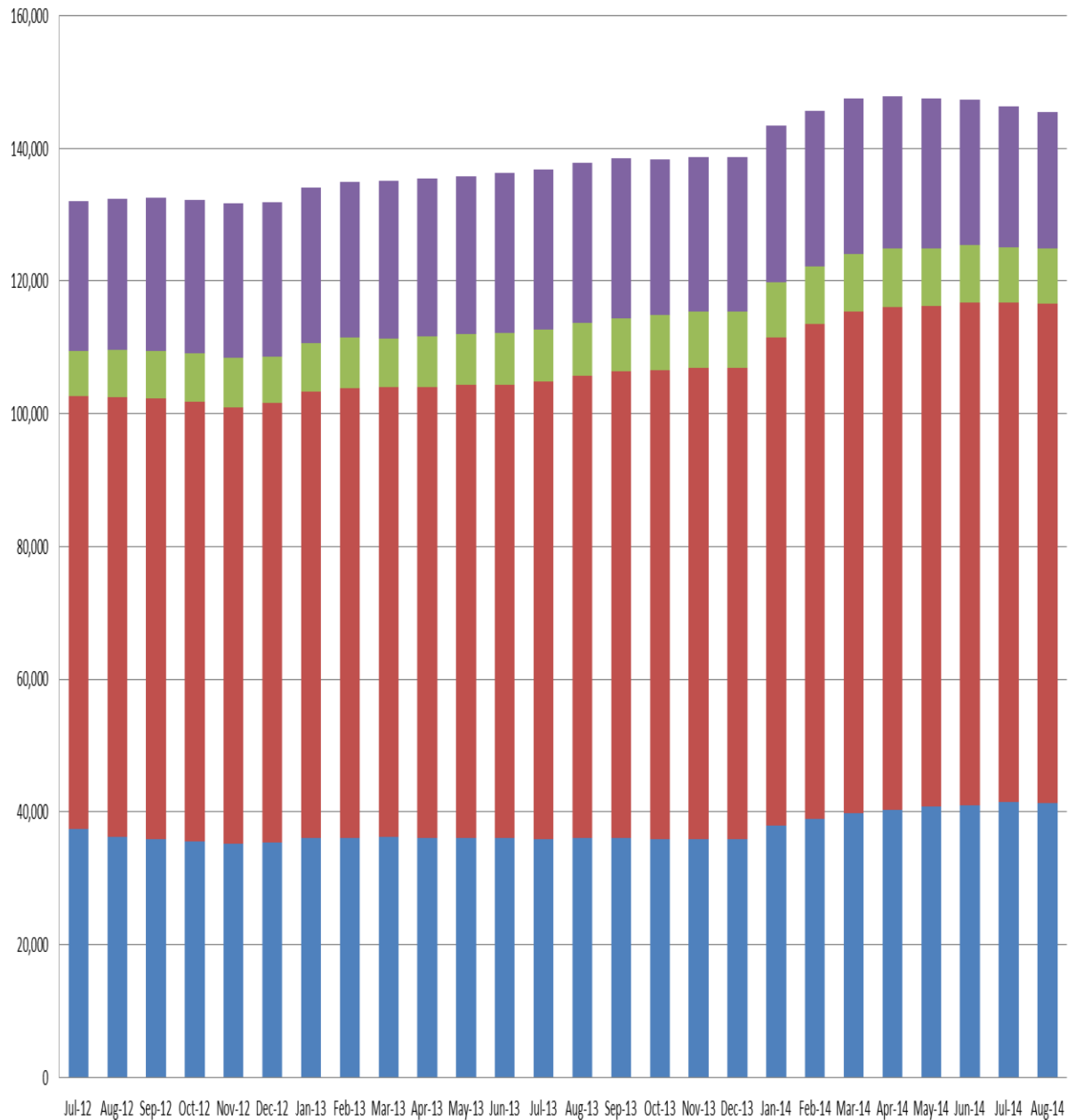
Some of the Medicaid programs managed by HRD include:

- Pharmacy
- Dental and Denturist
- Durable Medical Equipment (DME)
- Hospital: Inpatient, Outpatient, Critical Access Hospitals (CAHs)
- Audiology, Hearing Aids
- Optometry, Eyeglasses
- Therapies: Physical, Occupational, Speech
- Personal and Commercial Transportation, Ambulance, Specialized Non-Emergency
- Private Duty Nursing, Chiropractic, Nutrition
- Physician Services, Mid-Level practitioner; Podiatry, Laboratory and X-Ray
- Ambulatory Surgical Centers, Dialysis Clinics, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Community Health Centers (CHC)
- School Based Services
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Tribal and Indian Health Services (100% federally funded)
- Member Healthcare Assistance Programs:
 - Passport to Health
 - Team Care
 - Health Improvement
 - Nurse First

SFY 2014 Medicaid Expenditures



Medicaid and Healthy Montana Kids Enrollment



	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14
Total	131,992	132,460	132,524	132,197	131,668	131,898	134,055	134,967	135,060	135,397	135,821	136,217	136,844	137,786	138,426	138,347	138,742	138,726	143,389	145,584	147,586	147,855	147,428	147,407	146,370	145,405
HMK (formerly CHIP)	22,580	22,920	23,101	23,142	23,317	23,252	23,428	23,564	23,724	23,828	23,906	24,103	24,120	24,136	24,120	23,520	23,368	23,315	23,582	23,427	23,447	22,986	22,469	21,962	21,215	20,559
HMK, Plus (CHIP Fund/6-18 yrs)	6,761	6,979	7,148	7,268	7,321	7,085	7,253	7,484	7,388	7,497	7,566	7,716	7,800	7,873	7,935	8,238	8,397	8,529	8,399	8,570	8,681	8,736	8,680	8,622	8,437	8,233
HMK, Plus (Medicaid)	65,303	66,271	66,362	66,166	65,883	66,152	67,302	67,847	67,682	67,951	68,239	68,410	69,038	69,772	70,336	70,670	71,099	71,021	73,569	74,733	75,719	75,808	75,538	75,768	75,313	75,376
Adults Medicaid	37,348	36,290	35,913	35,621	35,147	35,409	36,072	36,072	36,266	36,121	36,110	35,988	35,886	36,005	36,035	35,919	35,878	35,861	37,839	38,854	39,739	40,325	40,741	41,055	41,405	41,237

SUMMARY OF MAJOR FUNCTIONS

Hospital Services

Hospital Services are provided in Montana through a network of 14 acute care facilities and 46 Critical Access Hospitals across the state. Medicaid reimburses for inpatient services, outpatient services and emergency care. Providing these services in Montana supports Montana's healthcare system and helps assure access to health services for all Montanans.

Medicaid will cover hospital care outside of the state only in special circumstances. Out of state coverage is limited to services that are: 1) not available in Montana (i.e. transplants); 2) for people who live on the border that may normally get their health care in Idaho, Wyoming, North Dakota or South Dakota; or 3) for Montanans who have traveled outside the state and are in need of services.

Physician and Mid-Level Providers Services

Medicaid reimburses for services including, but not limited to: office visits, lab tests, surgeries, childbirth, prenatal care and anesthesia. Approximately 73% of adults and 67% of children receiving Medicaid services during a year will receive services from a physician or mid-level provider. Medicaid's provider network includes over 3,731 physicians and mid-level practitioners in the State of Montana. Medicaid uses nationally developed payment structures, customized to Montana, to ensure equitable payments. The Resource Based Relative Value System (RBRVS) is described on page 33 of the 2015 Medicaid Report.

Pharmacy Services

The Medicaid Pharmacy program has 275 Montana pharmacies that provide appropriately prescribed medications. The program provides cost effective services across Montana and promotes appropriate use through provider education and pharmacy case management.

Drug coverage criteria are developed by physicians and pharmacists through the Drug Use Review Board. Through a contract with Mountain Pacific Quality Health, the Drug Use Review Board is made up of physicians, mid-level providers, and pharmacists from around Montana, which develop drug coverage criteria to ensure medications prescribed are appropriate, medically necessary and cost effective. Coverage determinations balance cost effective alternatives while allowing flexibility based on professional medical decisions.

HRD collects rebates from drug manufacturers for Medicaid, Mental Health Services Program and Healthy Montana Kids prescriptions. The rebates reduce the cost of the program to Montana by approximately \$52 million per year.

The Big Sky Rx program is a state funded program designed to complement the Medicare Part D drug benefit by providing premium assistance to eligible Montanans. Big Sky Rx staff determine eligibility for the program and individuals must have family income at or below 200% of the FPL and be enrolled in Medicare Part D. Big Sky Rx makes a payment of the Part D premium up to \$30 per month.

Dental and Denture Services

The Medicaid Dental program provides diagnostic, preventive, basic restorative, dentures and extraction services to people with Full Medicaid benefits and some individuals with Basic coverage. Services are provided to members by dentists, denturists, hygienist and oral surgeons. For members with Basic Medicaid, dental services are covered under the Essential for Employment or emergency services.

Tribal and Indian Health Services

Montana Medicaid works in coordination with Tribal Governments supporting services which allow Native Americans the ability to expand health care services in Indian country by increasing their access to medical care. Medicaid is working to enhance the availability of services in these settings which allows for better access, culturally appropriate care, and supports building health care capacity to serve Native Americans.

Montana Medicaid provides funding for medical services to Medicaid-eligible Native Americans through an Indian Health Service (IHS) facility and other approved tribal providers. The Medicaid program acts as the “pass-through” agency for IHS reimbursement, which is funded with 100% federal funds in accordance with federal laws and regulations.

In 2014, durable medical equipment; eyeglasses, and eyeglass dispensing/fitting fee, nursing homes, and outpatient surgeries have been added as separate billable services for IHS and Tribal facilities.

Tribal Medicaid Administrative Match (MAM) is a federal reimbursement program for the costs of “administrative activities” that directly support efforts to identify, and/or to enroll individuals in the Medicaid program or to assist those already enrolled in Medicaid to access benefits. Through MAM, tribes who have entered into contracts with DPHHS are reimbursed for allowable administrative costs directly related to the Montana State Medicaid plan or waiver service. The Montana Tribal Cost Allocation Plan allows Tribes to be reimbursed for Medicaid administrative activities that Tribes perform. The program, the first of its kind in the country, began July 1, 2008 with The Chippewa-Cree Tribe, The Confederated Salish and Kootenai Tribes and Northern Cheyenne Tribe currently participating.

School Based Services

The School Based Services program is a collaborative effort between DPHHS, the Office of Public Instruction (OPI) and local public schools. The program provides \$3,309,548 in 100% federal funding to schools throughout Montana by reimbursing for mandatory services provided in a school setting. The local tax burden on the citizens is reduced by Medicaid reimbursing for these services. OPI and local schools participating in the program certify the matching funds for the federal Medicaid expenditures. The certified match process saves the state general fund for what would otherwise be a required state obligation. Schools provide some services directly and contract for others. Schools provide health-related services that are written into a child’s individual education plan (IEP), such as: speech therapy, physical therapy, private duty nursing, audiology, personal care attendants, and special needs transportation.

The Montana Medicaid Administrative Claiming (MAC) program is a component of school-based services, which allows school districts and cooperatives to be reimbursed for some of the costs associated with administration of school-based health services. Each school is responsible for certifying matching funds necessary to obtain federal resources.

Rural Health Clinics and Federally Qualified Health Centers

Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) are designated Centers for Medicaid and Medicare reimbursement purposes that provide primary care and preventive services. A RHC or FQHC must be in a rural area, which is designated as a healthcare professional shortage area or which has a medically underserved population. These facilities are reimbursed for their costs of providing care using a prospective payment system (PPS), based on the cost of providing care.

Section 1915(b) Care Management Waiver Programs

The Passport to Health waiver has four components. All four components help people access and utilize services appropriately. The first service, **Passport to Health**, is the primary care case management program in which about 70% of Medicaid and HMK *Plus* eligible individuals are enrolled. A member chooses or is assigned a primary care provider who delivers all medical services or furnishes referrals for other medically-necessary care. Care management offered under the waiver enhances care, while reducing costs by minimizing ineffective or inappropriate medical care. The waiver is operated in all 56 counties.

This second component is **Team Care**, a program for individuals identified with inappropriate or excessive utilization of health care services. Members are identified for Team Care through claim reviews, provider referrals, and Drug Utilization Review Board referrals. Individuals are enrolled in Team Care for at least 12 months and receive services from one pharmacy and one medical provider. Approximately 600 Medicaid and HMK *Plus* members are currently enrolled in the Team Care program.

The third component, the **Health Improvement Program**, is an enhanced primary care case management program, administered in partnership with 13 Community Health Centers and the Fort Peck Tribes. The top five percent of high-cost, high-risk Medicaid and HMK *Plus* members are identified by Medicaid through the use of predictive modeling software and provider referrals. Care managers and health coaches employed by Community Health Centers provide in-person and telephonic health care management services to improve health outcomes, increase the ability of members to self-manage their health conditions and reduce costs.

This fourth component is **Nurse First**, a 24/7 nurse advice line available to all Medicaid and HMK *Plus* members. The advice line is operated by a vendor and through clinically-based algorithms directs callers to the most appropriate level of care: self-care, provider visit, or emergency department visit. Quality, access to care, and health outcomes are continuously monitored, tracked, and reported. Members and providers report satisfaction with these care management programs that document annual cost avoidance to Medicaid.

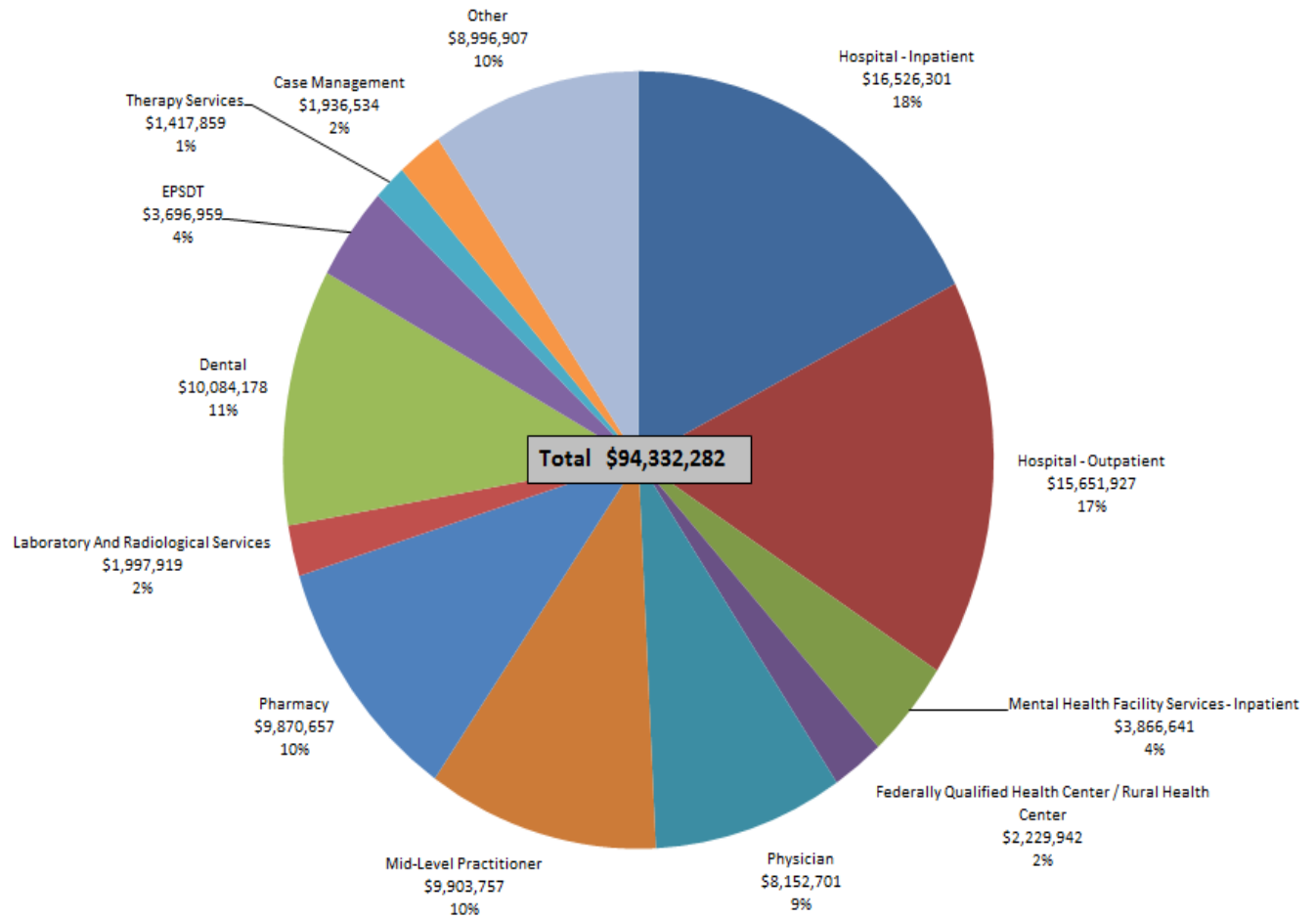
Section 1115 Plan First Family Planning Waiver

Plan First provides a limited set of family planning benefits available to a Medicaid eligibility group through a Section 1115(a) Medicaid waiver. Some of the services covered include office visits, contraceptive supplies, laboratory services, and treatment of STDs. Plan First offers Montana women ages 19 through 44 years of age living below 211% FPL to improve access to family planning services, have fewer unplanned pregnancies, and improved birth outcomes.

Section 1115 Basic Medicaid Waiver

Approved in 1996, effective through December 31, 2016, this waiver offers a limited Basic Medicaid benefit package of optional services to ‘able-bodied’ Medicaid eligible adults, age 21 to 64, who are not pregnant or disabled. Federal savings generated from able-bodied adults expand the waiver and cover up to 6,000 adults who previously qualified for the state-funded MHSP, at or below 150% FPL, who have schizophrenia, bipolar disorder, major depressive disorder, or a severe and disabling mental illness. Participants receive a basic package of Medicaid benefits that excludes: audiology, dental and denturist, durable medical equipment, eyeglasses, optometry and ophthalmology for routine eye exams, personal care services, and hearing aids. Excluded services are approved when necessary in an emergency situation or when they are essential to obtain or maintain employment.

SFY 2014 Healthy Montana Kids (CHIP-Funded) Expenditures



HEALTHY MONTANA KIDS PLAN OVERVIEW

Healthy Montana Kids (HMK) was created in 2008 through I-155, the citizen ballot initiative that created the Healthy Montana Kids Plan. I-155 passed in 2008 with 70% of the popular vote. The program provides health care coverage for children with family incomes between 144-261% FPL and makes children's health coverage affordable for over 20,000 Montana families.

Some services available under HMK include: physician office visits; well-child checkups; routine physicals; hospital in-patient and out-patient services; emergency visits; hearing and vision screenings; dental services; prescription drugs; transportation; and behavioral health services.

The Healthy Montana Kids *Plus* (HMK *Plus*) coverage group, formerly children's Medicaid covers children with family incomes between 0-109% FPL. The HMK *Plus* is a CHIP funded Medicaid program for children ages 6-18 with family income between 110-143% FPL. Children who are enrolled in the HMK *Plus* coverage group receive Medicaid benefits but the benefit costs are paid utilizing CHIP funds.

MEDICAID AND HEALTHY MONTANA KIDS REFORMS AND ACCOMPLISHMENTS

Dental Coverage Improvement for HMK Members

On July 1, 2014, HRD consolidated the HMK Basic and Extended Dental programs into one dental benefit package. This change reduced the administrative burden on providers and streamlined medically necessary dental services. The change increased the annual HMK basic dental benefit from \$1,412 to \$1,900 (the program reimburses providers at 85% of charges) while eliminating the HMK Extended Dental Benefit.

Pharmacy Benefit Management for HMK Members

On October 1, 2013, HRD assumed the pharmacy benefit management for HMK members. The HMK pharmacy benefit mirrors that of the HMK *Plus* population. HMK members and their families benefit from this change because it allows a seamless transition when members move between plans by having the same formulary, coverage policies and provider network. Member records remain in the pharmacy claims processing system allowing for enhanced case management and clinical decision making.

Physician Services

Reimbursement was increased January 1, 2013, for primary care physicians performing primary care services to the Medicare regional maximum level for evaluation and management (office) visits and vaccine administrations. The increase remains in effect through June 2015.

Tribal Nursing Home Reimbursement utilizing 100% Federal Funds

The Crow Tribe signed an agreement with IHS effective November 1, 2014, which allows the Department to reimburse the Crow Nursing Home (Awe Kualawaache Care Center in Crow Agency) utilizing 100% federal funds through the IHS/Tribal program rather than the Medicaid FMAP rate through the Senior and Long-Term Care (SLTC) Division. DPHHS is working with the Blackfeet Tribe to implement the same funding switch once an agreement is in place. Kelly Williams of the SLTC Division will provide additional information on this change.

Long Acting Reversible Contraceptives - LARC

The Centers for Medicaid and CHIP Services (CMCS), the U.S. Department of Health and Human Services Secretary's Advisory Committee on Infant Mortality (SACIM), the Health Resources and Services Administration, and the American Congress of Obstetricians and Gynecologists (ACOG) all recommend the use of LARCs at the time of delivery. According to the National Survey of Family Growth, 51% of pregnancies in the United States are unintended and more often than not, women don't return for postpartum contraceptive care after they leave the hospital. Unintended pregnancies are associated with an increased risk of poor health outcomes for mothers and babies, including delayed access to prenatal care, preterm birth, and negative physical and mental health effects. LARCs require no user intervention; they work over long periods, are highly effective, and are reversible.

The current inpatient payment methodology for hospitals does not increase payment when a LARC is inserted at time of delivery, hindering the availability of the service to members. Effective January 1, 2015, hospitals are reimbursed separately for the use of LARCs inserted at the time of delivery.

Early/Elective Inductions and Cesarean Sections

Elective inductions, cesarean sections, and early deliveries all increase the risk to both mother and infant and all increase the average hospital stay and costs for care for both mother and infant. Montana Medicaid pays for approximately 4,600 births a year, or 37.5% of Montana's births. Of these births:

- 25% of these births are induced; and
- 30% are cesarean sections.

These rates are similar to the rates of induction and cesarean section for the overall population of Montana.

Effective July 2014, birthing facilities were required to implement a policy regarding early elective inductions and cesarean sections. Starting October 1, 2014, reimbursement reductions are taken on claims for non-medically necessary inductions prior to 39 weeks and 0/7 days or non-medically necessary cesarean deliveries at any gestation.

- Facilities receive a 33% reduction in reimbursement.
- Critical Access Hospital payments are also reduced 33% during cost settlement.
- Physician, physician assistants, nurse midwives, and birth attendants who perform non-medically necessary inductions prior to 39 weeks and 0/7 days or non-medically necessary cesarean deliveries at any gestation will no longer receive the 12% policy adjustor for maternity services. Instead, they will be reimbursed at the standard rate.

Medicaid Patient Centered Medical Home (PCMH)

The medical home model of care offers a way to improve health care in America by transforming how primary care is standardized and delivered. The medical home model of care is based on the following core functions: Comprehensive Health Care, Patient-Centered Care, Care Coordination, Accessibility to Services and Enhanced Quality of Care.

Providers must meet National Committee for Quality Assurance (NCQA) qualifications and be approved through the Office of the Commissioner of Securities and Insurance as a PCMH. PCMH's will be responsible for reporting quality measures to DPHHS and the Office of the Commissioner of Securities and insurance focusing on patient outcomes rather than volume of service.

December 1, 2014, five in-state healthcare facilities were selected by DPHHS to pilot the Medicaid Patient Centered Medical Home Project. The facilities are strong models, providing care in large and rural communities for up to 9,000 members.

Cardiovascular Disease and Diabetes Prevention Program (DDP)

Since 2008, over 5,300 Montanans including over 230 Medicaid beneficiaries have participated in the DPP to help prevent cardiovascular disease and type 2 diabetes. The DPP is currently being implemented by 18 organizations, with an additional 2 satellite sites and 7 remote tele health delivery sites. The program is a 22 session group-based lifestyle intervention that promotes healthy eating and increased levels of physical activity to achieve the goal of 7% weight loss. This program is based on the National Institute of Health's DPP. A clinical trial found that an intensive diet and physical activity intervention targeting adults at high-risk for developing diabetes can reduce their risk of developing it by 58%. The Montana participants achieved significant weight loss with 34% losing at least 7% of their body weight, increased physical activity with 64%, and reductions in cardiovascular disease risk factors (e.g., high blood pressure, high cholesterol). HRD reimburses for the program and partners with the Public Health and Safety Division.



Little Carter

Carter was born with a complex genetic disorder called Prader-Willi Syndrome (PWS), the most common genetic cause of life-threatening obesity in children. PWS appears with a number of physical, mental and behavioral problems. Carter was born with extremely poor muscle tone, distant facial features, failure to thrive, lack of eye coordination and overall poor responses. With the assistance of Healthy Montana Kids, Carter's family and care managers are able to provide and arrange primary and preventative care for him to continually advance.

His early diagnosis and treatment continues to improve his quality of life, but his journey is just beginning. As a youngster, Carter requires a laundry list of care and preventative treatments such as: nutritional assistance, human growth hormone treatments, treatment for sleep disturbances and mental health care are just a few. As he gets older he will require treatments for conditions he or his family has yet to experience.

The past 3 years, Carter has worked weekly with physical therapists to improve his gross motor skills (sitting up, crawling and walking) strengthening and developing his muscles and occupational therapy which help develop his fine motor skills (pinch grasp, holding objects, etc.).

Carter's family lives in rural Montana and must travel in all sorts of weather to receive healthcare. His family drives him to all his well-child check-ups and every Thursday to physical, occupational, speech therapy, whether in-state or out-of-state. The HMK plan provides prior authorized transportation services to help with mileage, meals and lodging if needed.

In the past two years, Carter has grown into this little amazing miracle, using his feet to push himself along the floor, rolling his body, pulling himself up to a standing position with the help of furniture and his custom orthotics, climbing up and down stairs, sitting for long periods of time, and eating with his family at the table. In 2014, Carter started Head Start and is able to interact with other children in his community. These milestones couldn't have happened for Carter without his family's devotion and the many services provided by HMK plan.



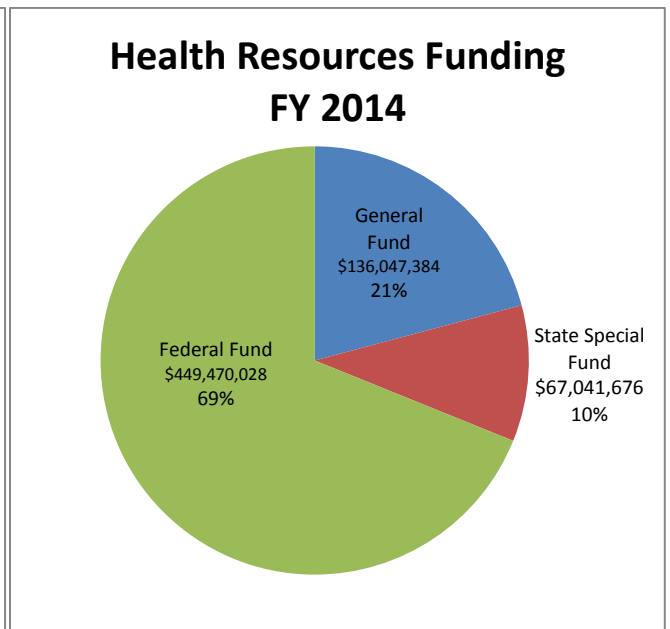
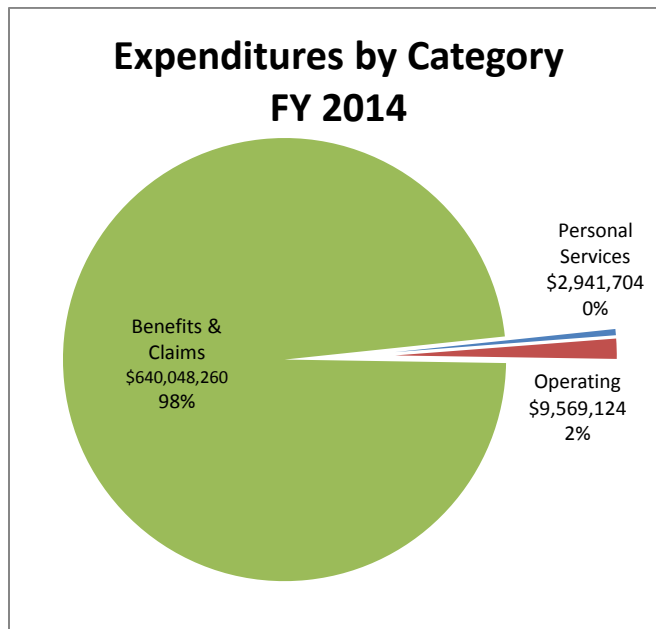
Every child is different with or without a disability, but with services the minds and bodies of each child can excel.

2017 BIENNIUM GOALS AND OBJECTIVES

Department of Public Health and Human Services Health Resources Division	
Goals and Objectives for the 2017 Biennium January 2015	
Goal: Assure necessary healthcare is available to all eligible Montanans.	
Objective	Measures
Reduce the number of uninsured Montana Children	<ul style="list-style-type: none">• The number of low to moderate income Montana children enrolled in the Healthy Montana Kids program is increased.
Objective	Measures
Maintain systems to accurately and adequately pay for healthcare services	<ul style="list-style-type: none">• Modifications that maintain access and prevent adverse findings from program reviews are implemented.
Objective	Measures
Maintain adequate access to medical services for Medicaid	<ul style="list-style-type: none">• Provider networks are monitored and maintained at current levels with priorities for primary care providers.
Objective	Measures
Finance healthcare for low income Montanans in accordance with state and federal directives	<ul style="list-style-type: none">• Favorable outcomes in program and financial reviews and audits are maintained.• Approved amendments to ensure state Medicaid plans and waivers are maintained.

**THE FOLLOWING FIGURES PROVIDE FUNDING AND EXPENDITURE INFORMATION FOR
FY 2014 FOR HEALTH RESOURCES DIVISION (INCLUDES HMK)**

	FY 2014 Actual Expenditures	FY 2016 Request	FY 2017 Request
Health Resources Division			
FTE	54.00	51.62	51.62
Personal Services	\$2,941,704	\$3,783,548	\$3,781,330
Operating	\$9,569,124	\$10,261,158	\$10,286,516
Equipment	\$0	\$0	\$0
Grants	\$0	\$0	\$0
Benefits & Claims	\$640,048,260	\$749,275,017	\$803,567,697
Transfers	\$0	\$0	\$0
Debt Services	\$0	\$0	\$0
Total Request	\$652,559,088	\$763,319,723	\$817,635,543
General Fund	\$136,047,384	\$169,125,480	\$184,746,330
State Special Fund	\$67,041,676	\$72,298,529	\$74,155,299
Federal Fund	\$449,470,028	\$521,895,714	\$558,733,914
Total Request	\$652,559,088	\$763,319,723	\$817,635,543



CHANGE PACKAGES (SEE LFD BUDGET ANALYSIS, PAGES B-88 TO B-91)

PL 1100444 Statewide 4% FTE Reduction – Program 11

- The 2015 biennium budget included a 4% vacancy savings reduction. Language included in the boilerplate of HB 2 passed by the 2013 Legislature, indicated legislative intent that the 4% vacancy savings be made permanent as an FTE reduction for the 2017 biennium. Change package 1100444 includes a reduction of 2.38 FTE each year of the biennium and \$274,945 total funds for the biennium to accomplish the FTE reduction.
- LFD reference is on page B-92, correlates to DP 98.

Fiscal Year	General Fund	State Special	Federal	Total Request
FY 2016	(55,037)	(11,007)	(71,547)	(137,591)
FY 2017	(54,942)	(10,988)	(71,424)	(137,354)
Biennium Total	(109,979)	(21,995)	(142,971)	(274,945)

PL 1111001 Medicaid Benefit Other Caseload Breast and Cervical

- This change package includes a reduction of \$241,766 in general fund and \$749,791 in federal funds to reflect the budgetary changes due to a decrease in caseload growth for the Breast and Cervical Cancer (BCC) program. The rate of decrease in this program is estimated at 4.12% per year due to the movement of clients to the Health Insurance Marketplace and the consequent reduction to BCC program. Funding in FY 2016 is 24.22% general fund and 75.78% federal funds. Funding in FY 2017 is 24.66% general fund and 75.34% federal funds.
- Serves members under 65 years of age, uninsured and have a family gross income at or below 200% of the FPL.
- Early detection of BCC allows for early intervention and treatment.
- Serves approximately 180 members per month.
- LFD reference is on page B-94, correlates to 1111001 Med Ben Other Cload Breast and Cervical

Fiscal Year	General Fund	State Special	Federal	Total Request
FY 2016	(95,634)		(299,222)	(394,856)
FY 2017	(146,132)		(450,569)	(596,701)
Biennium Total	(241,766)		(749,791)	(991,557)

PL 1111002 Medicaid Benefit Caseload Clawback

- This present law adjustment requests \$1,003,976 in general fund over the biennium to provide the necessary financing to increase the clawback payment, which is subject to changes in caseload. The Medicare Modernization Act (MMA) requires the federal government to pay prescription drug costs for Medicaid members, who had previously been covered in part by states. States are required to pay back to the federal government a phased-down contribution, known as clawback, of some of the costs that states no longer are expected to finance in benefits. The clawback amount is adjusted each year by CMS based on Montana's medical expenditures. The funding is 100% general fund.
- LFD reference is on page B-94, correlates to 1111002 Med Ben Other Cload Clawback.

Fiscal Year	General Fund	State Special	Federal	Total Request
FY 2016	382,811			382,811
FY 2017	621,165			621,165
Biennium Total	1,003,976			1,003,976

PL 1111003 Medicaid Benefit Federal Caseload HRD

- This present law adjustment requests federal funds of \$14,609,206 in FY 2016 and \$22,971,056 in FY 2017 to fund caseload growth for IHS, tribal facilities and School Based programs within HRD. Funding is 100% federal funds.
- Increases access for people, and provides services closer to home.
- Schools work with DPHHS to provide the state match.
- Medicaid reimburses per outpatient visit method rather than a day visit for IHS services.
- The average population served per month is: 6,455 in IHS and tribal facilities, and 975 in schools.
- LFD change packages are: 1111030 Med Ben CLoad Indian Health Services (Page B-95) and 110031 School Based Physical Health Services (Page B-96).

Fiscal Year	General Fund	State Special	Federal	Total Request
FY 2016			14,609,209	14,609,209
FY 2017			22,971,056	22,971,056
Biennium Total			37,580,265	37,580,265

PL 1111005 Medicaid Benefit Other Caseload Medicare Buy In

- This present law adjustment requests \$10,358,870 total funds over the biennium with \$3,613,940 in general fund cover expected increases in premiums for Medicare Part A and Part B. This program is mandated by federal law (Title XVIII of the Social Security Act).
- Provides the premiums for Medicare Part A and Part B to eligible members.
- Cost effective program that allows the state Medicaid programs to purchase Medicare primary coverage through premium payments for low income members.
- Medicare covers the costs of most services for the individual and Medicaid is only liable for costs of non-Medicare covered services, co-insurance, and deductibles.
- LFD reference is on page B-96, correlates to 1110062 Med Ben Core Cload Medicare Buy In.

Fiscal Year	General Fund	State Special	Federal	Total Request
FY 2016	1,334,677		2,513,872	3,848,549
FY 2017	2,279,263		4,231,058	6,510,321
Biennium Total	3,613,940		6,510,321	10,358,870

PL 1111006 Medicaid Benefit Core Caseload Physical Health

- This present law adjustment for caseload growth in the HRD covers the increase in the number of eligible individuals, utilization, acuity levels and cost per service for medical care. This change package requests \$160,089,532 in total funds. The biennial funding is \$55,537,209 in general fund, \$293,195 in state special revenue, and \$104,259,127 in federal funds.
- Reflects an increase in number of members, utilization, and patient acuity levels.
- Some of the services include inpatient, outpatient, dental, pharmacy, and physicians.
- Medicaid is an entitlement.
- Serves approximately 68% children and 32% adults.
- Current, enrollment show 84,095 children and 44,535 adults.
- LFD reference is on page B-96 and B-97, correlates to 1110060 Med Ben Core Cload Hospital and Physician Services (Page B-96), 1110061 Med Ben Core Cload Acute Services (Page B-96), and 1110063 Med Ben Core Cload Pharmacy (Page B-97).

Fiscal Year	General Fund	State Special	Federal	Total Request
FY 2016	22,505,235	293,195	42,940,988	65,739,418
FY 2017	33,031,975	0	61,318,139	94,350,114
Biennium Total	55,537,210	293,195	104,259,127	160,089,532

PL 1111007 HMK Caseload (Formerly CHIP)

- This present law adjustment reflects the caseload growth for HMK. This caseload consists of the number of eligible children, utilization, and patient acuity levels. The change package requests \$27,395,425 in total funds. The biennial funding is \$3,869,133 in general fund, \$2,809,688 in state special revenue, and \$20,716,604 in federal funds.
- The population is the 143% - 261% FPL.
- Serves approximately 24,000 children per year.
- Services are provided through a contract with Blue Cross Blue Shield.
- CHIP services are CHIP funded.
- LFD reference is on page B-94, correlates to 110013 HMK CHIP Funded Services.

Fiscal Year	General Fund	State Special	Federal	Total Request
FY 2016	1,687,289	1,031,857	8,507,741	11,226,887
FY 2017	2,181,844	1,777,831	12,208,863	16,168,538
Biennium Total	3,869,133	2,809,688	20,716,604	27,395,425

PL 1111008 HMK *Plus* Caseload

- This present law adjustment reflects the caseload growth for the Healthy Montana Kids *Plus* Medicaid CHIP funded group. This caseload consists of the number of eligible children, utilization, and patient acuity levels. This change package requests \$17,490,654 in total funds. The biennial funding consists of \$4,263,999 in state special revenue and \$13,226,655 in federal funds.
- The children in this group receive Medicaid benefit, but are funded by the CHIP grant.
- Serves approximately 10,000 children per year.
- The Medicaid group is 109-143% FPL.
- This program was added in 2008 due to a Montana approved initiative.
- LFD reference is on page B-94, correlates to 110013 HMK CHIP Funded Services.

Fiscal Year	General Fund	State Special	Federal	Total Request
FY 2016		1,745,874	5,462,523	7,208,397
FY 2017		2,518,125	7,764,132	10,282,257
Biennium Total		4,263,999	13,226,655	17,490,654

PL 1111010 Medicaid Administration Contractual Adjustments

- These funds are used to maintain existing services for the administration of contracts in the Health Resources Division. The request adjusts the base year expenses from the FY 2014 level. The increase is necessary to provide services for both the Medicaid and Healthy Montana Kids programs.
- Contracts to assist in program management for services assisting both the Medicaid and Healthy Montana Kids programs.
- Services are related to utilization review for preferred drug list, state maximum allowable costs for pharmaceuticals, drug use review, prior authorization on drug, evidence based medicine, hospital audits, and transportation.
- Assist in controlling costs which serve over 110,000 clients.
- LFD reference is on page B-94, correlates to 1111010 MED Admin Contractual Adjustments.

Fiscal Year	General Fund	State Special	Federal	Total Request
FY 2016	158,137		158,137	316,274
FY 2017	158,137		158,137	316,274
Biennium Total	316,274		316,274	632,548

PL 111011 Medicaid Administrative Claiming

- This change package requests \$725,000 over the biennium in federal funds only. This present law adjustment is made to maintain existing services for the administration of contracts in the Health Resources Division. It adjusts the base year expenses from the FY 2014 level. The adjustment is necessary to provide Medicaid Administrative Claiming and Medicaid Administrative Match funding to schools and tribal nations for Medicaid.
- Provides the administrative match claiming with the seven tribal governments and 76 school districts.
- Provides federal reimbursements for eligible Medicaid Title XIX outreach and administrative services performed by both the school districts and tribal nations.
- Assists over 84,000 children who qualify under Healthy Montana Kids.
- LFD reference is on page B-93

Fiscal Year	General Fund	State Special	Federal	Total Request
FY 2016			350,000	350,000
FY 2017			375,000	375,000
Biennium Total			725,000	725,000

PL 111012 Medicaid Benefit Other FMAP Breast and Cervical

- This present law adjustment is necessary to maintain existing services for the Breast and Cervical Cancer programs in the Health Resources Division. This change package requests a general fund amount of \$27,522 in FY 2016 and \$39,498 in FY 2017 with offsetting federal funds reductions for each year. The total cost for the program does not change.
- Reflects the federal program participation change for the Medicaid Breast and Cervical Cancer.
- LFD reference is on page B-94, correlates with 111001 Med Ben Other Cload Breast and Cervical.

Fiscal Year	General Fund	State Special	Federal	Total Request
FY 2016	27,522		(27,522)	0
FY 2017	39,498		(39,498)	0
Biennium Total	67,020		(67,020)	0

PL 111013 HMK (CHIP) FMAP

- This present law adjustment is necessary to maintain existing services for the HMK (formerly CHIP) program in the Health Resources Division. This change package requests a state special revenue amount of \$450,422 in FY 2016 and \$635,830 in FY 2017 with offsetting federal funds reductions for each year. The total cost for the program does not change.
- Reflects the federal program participation change for Healthy Montana Kids (144-261% FPL)
- LFD reference is on page B-94, correlates with 110013 HMK CHIP Funded Services.

Fiscal Year	General Fund	State Special	Federal	Total Request
FY 2016		450,422	(450,422)	0
FY 2017		635,830	(635,830)	0
Biennium Total		1,086,252	(1,086,252)	0

PL 111014 HMK Plus FMAP

- This present law adjustment is necessary to maintain existing services for the HMK (Medicaid CHIP-Funded) program in the Health Resources Division. This change package requests a state special revenue amount of \$945,534 in FY 2016 and \$1,014,824 in FY 2017 with offsetting federal funds reductions for each year. The total cost for the program does not change.
- Reflects the federal program participation change for Healthy Montana Kids group (110-143% FPL)
- LFD reference is on page B-94, correlates with 110013 HMK CHIP Funded Services.

Fiscal Year	General Fund	State Special	Federal	Total Request
FY 2016		945,534	(945,534)	0
FY 2017		1,014,824	(1,014,824)	0
Biennium Total		1,960,358	(1,960,358)	0

PL 111015 Medicaid Benefit Core FMAP Physical Health

- This present law adjustment is necessary to maintain existing services for the Medicaid Core Physical Health programs in HRD. This change package requests a general fund amount of \$4,711,276 in FY 2016 and \$6,040,491 in FY 2017 with offsetting federal funds reductions for each year. The total cost for the program does not change.
- Reflects the federal program participation change for the Medicaid program that covers physical health services.
- LFD reference is on page B-96 and B-97, correlates to 1110060 Med Ben Core Cload Hospital and Physician Services (Page B-96), 1110061 Med Ben Core Cload Acute Services (Page B-96), and 1110063 Med Ben Core Cload Pharmacy (Page B-97).

Fiscal Year	General Fund	State Special	Federal	Total Request
FY 2016	4,711,276		(4,711,276)	0
FY 2017	6,040,491		(6,040,491)	0
Biennium Total	10,751,767		(10,751,767)	0

PL 111021 Medicaid Benefit Other FMAP Hospital Utilization Fee

- This request adjusts the base year expenses from the FY 2014 FMAP rate. This change package requests state special revenue in the amount of \$663,937 in FY 2016 and \$880,867 in FY 2017 with offsetting federal fund reductions for each year. The total cost of the program does not change.
- Reflects the federal program participation change for the hospital utilization fees.
- LFD reference is on page B-95, correlates to 1111021 Med Ben Other Hospital Util. Fee.

Fiscal Year	General Fund	State Special	Federal	Total Request
FY 2016		663,937	(663,937)	0
FY 2017		880,867	(880,867)	0
Biennium Total		1,544,804	(1,544,804)	0

NP 111022 Provider Rate Increase HMK (CHIP)

- This new proposal requests a 2% provider rate increase in each year of the biennium for the HMK programs processed by DPHHS. These include pharmacy, dental, vision, FQHC, RHC and Community Based Psychiatric Rehabilitation and Support (CBPRS). The change package requests \$690,712 in total funds with \$70,000 in general fund.
- LFD reference is on page B-98, correlates to 1111022 – PRI HMK(CHIP).

Fiscal Year	General Fund	State Special	Federal	Total Request
FY 2016	35,000	20,763	174,474	230,237
FY 2017	35,000	78,553	346,922	460,475
Biennium Total	70,000	99,316	521,396	690,712

NP 111023 Provider Rate Increase HMK Plus (CHIP Funded)

- This new proposal requests a 2% provider rate increase in each year of the biennium for the HMK programs processed by DPHHS. These include pharmacy, dental, vision, FQHC, RHC and CBPRS. This change package requests \$1,219,952 in total funds with \$299,051 in state special revenue.
- LFD reference is on page B-99, correlates to 1111023 PRI HMK (CHIP-Funded).

Fiscal Year	General Fund	State Special	Federal	Total Request
FY 2016	0	98,491	308,160	406,651
FY 2017	0	200,560	612,742	813,302
Biennium Total	0	299,051	813,302	1,219,953

NP 111024 Provider Rate Increase Medicaid Benefit Medicaid Core

- This new proposal requests a 2% provider rate increase in each year of the biennium. This change package requests \$17,653,404 in total funds with \$6,161,038.
- LFD reference is on page B-99, correlates to 1111024 PRI Med Ben Medicaid Core.

Fiscal Year	General Fund	State Special	Federal	Total Request
FY 2016	2,040,733		3,843,735	5,884,468
FY 2017	4,120,305		7,648,631	11,768,936
Biennium Total	6,161,038		11,768,936	17,653,404

NP 111025 Provider Rate Increase Medicaid Benefit Breast and Cervical Cancer

- This new proposal requests a 2% provider rate increase in each year of the biennium. This change package requests \$254,961 in total funds with \$80,092 in general fund.
- LFD reference is on page B-98, correlates to 1111025 PRI Med Ben Breast & Cervical Cancer.

Fiscal Year	General Fund	State Special	Federal	Total Request
FY 2016	20,584		64,403	84,987
FY 2017	59,508		110,466	169,974
Biennium Total	80,092		169,974	254,961